ABANDONMENT IN THE PHYSICIAN-PATIENT RELATIONSHIP

ROBERT S. CRAUSMAN MD, MMS, AND JAY M. BARUCH, MD

Now being admitted to the high calling of the physician, I solemnly pledge to dedicate my life to the care of the sick, the promotion of health and the service of humanity...

Excerpt from the physician's oath taken by graduates of Brown's Medical School

The Board of Medical Licensure and Discipline [BMLD] is charged with protecting patient safety and assuring that Rhode Island's physicians meet their ethical and legal obligations. For guidance, the Board considers the American Medical Association code of ethics, the law (particularly Chapter 5-37 of the Rhode Island general law) and the collective wisdom of its members to define reasonable and appropriate standards. The Board also educates our medical and lay communities about these matters.

One recurring issue for the Board is potential patient abandonment by the treating physician. What follows is a primer on the *ethical dismissal of the patient from your practice.* However, before addressing this sensitive and emotional issue, one must consider the inherent duties and obligations of the parties in the physician-patient relationship.

PHYSICIAN-PATIENT RELATIONSHIP:

The physician-patient relationship is based on trust. Patients - whether acutely ill or "potentially" ill - are vulnerable, usually weak, and almost always dependent on the knowledge and expertise of their physicians. They undress, offer intimate information, express deep fears. Physicians, in turn, are expected to respect their patients' autonomy, uphold their dignity, hold information with the strictest confidence, and ultimately act in a skilled, beneficent manner. A power imbalance exists, one that could lead to abuses if the medical profession wasn't expected to respect certain ethical duties. For example, in business or sports, the weakness of others may be considered an opportunity for advantage. Thus, in the physician-patient relationship, the fiduciary bond is fortified by the notion that the patient comes first.

The fiduciary nature of this bond is built upon characteristics of doctoring that distinguish it from other "professions." It has been written that physician knowledge is held in trust for patients, that it doesn't belong to the physician alone. This idea emanates in part from the nature of medical education. For example, the acts of dissection and "touching" patients for purposes of learning are privileged acts. (Outside the medical context, these same acts violate the law). Physicians, moreover, take a public oath at graduation. They profess their duties to future patients. Ultimately, patients expect and are entitled to know that physicians place the interests of their patients ahead of their own.[1]

What about the duties of patients in this relationship? Should physicians expect certain obligations from them? Perhaps honesty in the disclosure of health matters, compliance with diagnostic or therapeutic treatment plans, including keeping appointments, and behavior that respects the professional environment and doesn't interfere with the treatment of others. Others may argue these statements, and whether patients should be expected to obey them, but the point is that relationships, even those marked by power imbalance, are never purely one-sided.[1]

Except for emergency care, the physician-patient relationship begins voluntarily, by mutual agreement. A physician may not, however, discriminate against any particular class or category of patients. With regard to third-party payers, a physician may elect to participate or not to participate: it is permissible not to accept patients into your practice who have a particular health insurance. The standard, however, must apply equally to all patients with a particular health insurance (e.g., a physician may decide not to accept new patients with a particular health insurance; a physician may not reject a patient due to his/her health insurance if that physician accepts other new patients with that coverage).

Once entered, the relationship between physician and patient becomes a binding social contract—based on ethical principles and duties mentioned above—that is fortified by legal standards. This is not to say that physicians are obligated to care for patients over a lifetime, nor can physicians be compelled to

Table 1: Guidelines for ethical dismissal of a patient from your practice

1. The practice should have a formal written policy delineating the conditions/ circumstances which need to be satisfied prior to dismissing a patient.
2. The efforts made to resolve the differences between physician and patient that precipitate the dismissal should be clearly documented in the medical record.
3. The reasons for dismissal should be clearly documented in the medical record.
4. The patient should be notified in writing (certified mail recommended) with return receipt requested.
5. A reasonable transition period during which the physician will continue to serve must be offered (30 to 60 days).
6. The physician should facilitate a transfer of care and records to a new physician acceptable to the patient.

violate fundamental personal values, accepted standards of medical practice, or the law.

Physicians are entitled to remuneration for their services, and patients should expect to pay for care. Although the calculus is complicated by the superimposition of third-party payers, and debate over just compensation, the relationship at its root is a social contract between two individuals, and patients shouldn't be abandoned because of third-party concerns.

Ethical discontinuation of the physician-patient relationship:

Physician-initiated dismissal of a patient should be rare. Once the relationship is initiated, the physician is duty bound and should seek to terminate it only in extreme circumstances. Legally, physicians can withdraw from the relationship, and without giving a reason, as long as certain procedural standards are upheld. However, the ethical consequences of such actions without reasonable and justifiable reasons are a different matter, potentially leading to disrespect and distrust of the individual physician and compromising the public trust and confidence in the profession as a whole. Trust and confidence in this relationship is a vital component of medical practice [2,3,4,5] and patients, society, and the profession of medicine would be harmed if the termination of the physician-patient relationship were less rigorously avoided.

Ethical considerations dictate that patient dismissal should occur only after genuine attempts to resolve differences between physician and patient have failed. At this point the physician must notify the patient and subsequently facilitate the transfer of care (and medical records) to another physician acceptable to the patient.

Table 1 outlines a six-point review outlining the recommended elements that should be satisfied for the Board to be confident that the dismissal of a patient from a physician's practice meets both ethical and legal standards.

Of note; patients may discontinue their relationship with a physician without notice or cause, at any time, and are entitled to the information contained in their medical records. This entitlement is valid even if there is an outstanding financial obligation. The patient's healthcare must come first.[4] By statute in the State of Rhode Island it is a defining example of unprofessional conduct not to provide these records upon appropriate request. Regulations limit Reasonable record copying fees to $15 plus $0.25 per page for the first 100 pages and $.10 per page two thereafter to a maximum of $75. Physicians in the State have been sanctioned for knowingly disregarding this regulation.

Abandonment

Patient abandonment has been defined as the unilateral withdrawal by a physician from a patient's care without first formally transferring that care to another qualified physician who is acceptable to the patient.[5] Abandonment is not only ethically problematic but also another defining act of unprofessional conduct in the State of Rhode Island warranting sanction by the Board. In response to a finding of unprofessional conduct, the Board is empowered to take the following actions: revoke, suspend, limit or restrict a physician's license; require a period of probation; mandate a formal course of instruction or continuing medical education; administer a reprimand or any other condition(s) or restrictions deemed appropriate under the circumstances.[4]

Special circumstances:

Third-party payors:

Many patients have their health insurance change. Some estimate that a typical patient will change health insurance at least once every five years. All physicians do not accept all health insurance, nor are they required to do so. Consequently, patients who have established a physician-patient relationship with a particular physician often find themselves covered by a health insurer that either does not recognize the particular provider or that is not accepted by the provider.

This presents a dilemma for the treating physician. Physicians are entitled to be compensated for their services. Physicians, or the facilities that employ them, must also operate a fiscally sound business. Patients, however, cannot be abandoned.

To prepare for this eventuality, physicians should develop a clear policy and procedure that is transparent and equally applied. The obligation to facilitate a transfer of care remains paramount and is generally satisfied by a willingness to readily transfer records to a newly assigned physician. Transfer of care can be difficult for patients involved in a complicated treatment protocol or multi-staged surgery. *In these instances the physician, patient and insurer must each demonstrate initiative and flexibility in the interest of the patient.* An insurer may be asked to extend coverage to allow for an out-of-network provider. A patient may be asked to assume a required copay. A physician may be asked to offer a payment plan. It is distinctly unusual that such care should be rendered without compensation. At times of conflict, or to provide assistance in order to avoid conflict, the Department of Health through the Board of Medical Licensure and Discipline, the Division of Managed Care, and the Division of Facilities Regulation can often be helpful.

Vacation, CME meetings, days off, etc.:

Physicians can and should take time away from their medical practice; but they must provide for continuity of care and availability of medical records. Cross-coverage plans should be readily understandable and accessible to patients; e.g., when a patient calls the office, phone number instructions regarding what to do, or whom to call should be readily offered.

Illness:

Physicians get sick. Although unplanned, and at times tragic, there is still an obligation to provide continuity of care for patients. Our medical community, the Rhode Island Medical Society, our State's subspecialty organizations and the Board of Medical Licensure and Discipline are outstanding resources and should be used.

Closing a practice:

When closing one's practice, whether for illness or retirement, physicians have an obligation to assure adequate notifi-

cation of patients, continuity of care, and protection and availability of medical information. Medical records must generally be retained for at least five years. Physicians are responsible for keeping these records safe, confidential and accessible. If transferring these records to another physician or practice, a formal written agreement must be in place. Patients must be notified in advance and a reasonable transition period offered. The Rhode Island Medical Society offers a useful information packet on closing a medical practice which is available upon request. (401-331-3207)

GROUP PRACTICE:

Physicians in a group practice often have increased flexibility with regard to continuity of care. Provided that patients are informed regarding the involvement of colleagues from the practice in their ongoing care, the practice can assist in many of the obligations traditionally assigned to the individual physician. Physicians may also often leave a group practice with relative ease. The duty to notify patients, however, remains. The need to respect patient's rights would also dictate that the group practice openly disclose the departing physicians new work address.

CONCLUSION

The physician-patient relationship is the heart of the clinical practice of medicine. As we physicians strive to balance science, humanism, economics, ethics and the law, we must maintain this focus. Abandonment, and the fear of abandonment, harms our patients, our profession and society at large. Yet there are circumstances where it is appropriate to dismiss a patient from one's practice. Despite expectations, all relationships aren't beneficial. Kindly keep in mind existing standards for the ethical dismissal of patients, that patients should be treated with dignity and respect even when ending the relationship, and that the public trust in physicians is precious and fragile and, once lost, may be difficult to restore.

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Robert S. Crausman, MD, MMS, is Chief Administrative Officer, Rhode Island Board of Medical Licensure and Discipline, and Associate Professor of Medicine, Brown Medical School.

Jay M. Baruch, MD, is Clinical Assistant Professor of Surgery(Emergency Medicine), Brown Medical School.

CORRESPONDENCE:
Robert S. Crausman, MD, MMS
Phone: (401) 222-7888
Fax: (401) 222-2158
e-mail: RSCrausman@Aol.com